

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/12/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G436		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 02/28/2012	
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 11 WASHINGTON ST BROWNSBURG, IN 46112			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{W 000}	<p>INITIAL COMMENTS</p> <p>This visit was for a post certification revisit (PCR) to complaint #IN00092140 investigated on 7/11/11.</p> <p>This visit was in conjunction with the recertification and state licensure survey.</p> <p>Complaint number IN00092140, Corrected</p> <p>Survey Dates: February 21, 22, 23, 28, 2012</p> <p>Facility Number: 000950 Aims Number: 100244690 Provider Number: 15G436</p> <p>Surveyor: Mark Ficklin, Medical Surveyor III</p> <p>Transitional Services #000950 was found to be in compliance with 42 CFR, Part 483, Subpart I and 460 IAC 9 in regard to the PCR to the investigation of complaint #IN00092140.</p> <p>Quality Review completed on 3/9/12 by Tim Shebel, Medical Surveyor III.</p>			{W 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.